PRINTED: 09/21/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES							OM	IB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP	LE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDDIC	,	01	COMPL	LETED
		155272	- 1	LDINC	J		09/07/2	2011
		<u> </u>	B. WIN		DET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R						
KINDDE	D TO ANOITION AL	OADE AND DELLAD OACTLETON				82ND ST		
KINDREI	D TRANSITIONAL (	CARE AND REHAB-CASTLETON		I INI	JIAN	IAPOLIS, IN46250		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAC	3	DEFICIENCY)	VIE.	DATE
K0000			1					
	A Life Safety Co	ode Recertification and	l K	0000				1
	State Licensure Survey was conducted by			0000				
		•						
		e Department of Health in						
	accordance with	42 CFR 483.70(a).						
	Survey Date: 09	9/07/11						
	Facility Number	·· 000172						
	1							
	Provider Numb							
	AIM Number: 1	100267130						
	Surveyor: Mark	Caraher, Life Safety						
	Code Specialist	, , , , , , , , , , , , , , , , , , ,						
	Couc specialist							
	A A A L. L. T. L.C. C. C.	d Calana Walad						
		ety Code survey, Kindred						
		e and Rehab - Castleton						
	was found not in	n compliance with						
	Requirements for	or Participation in						
	Medicare/Medic	eaid, 42 CFR Subpart						
		Safety from Fire and the						
	` ′ ′	•						
		the National Fire						
		ciation (NFPA) 101, Life						
	Safety Code (LS	SC), Chapter 19, Existing						
	Health Care Occ	cupancies and 410 IAC						
	16.2.	•						
	This one store for	naility was datarmined to						
		acility was determined to						
	•••	11) construction and was						
	fully sprinklered	l. The facility has a fire						
	alarm system wi	th smoke detection in the						
	1	open to the corridors and						
		_						
	an resident sleep	oing rooms. The facility						1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Facility ID: If continuation sheet KNMS21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155272	B. WING		09/07/2011
	PROVIDER OR SUPPLIER	CARE AND REHAB-CASTLETON	STREET A 5226 E	ADDRESS, CITY, STATE, ZIP CODE 82ND ST IAPOLIS, IN46250	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	has a capacity of 122 at the time o	160 and had a census of f this survey.			
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/09/11.				
	The facility was	found not in compliance			
	I -	entioned regulatory			
	requirements as				
following:					
K0018	Doors protecting of	corridor openings in other			
SS=E	than required enclexits, or hazardou doors, such as the solid-bonded core resisting fire for at sprinklered buildin resist the passage impediment to the are provided with	losures of vertical openings, s areas are substantial open constructed of 1¾ inch wood, or capable of least 20 minutes. Doors in least 20 minutes of smoke. There is no closing of the doors. Doors a means suitable for closed. Dutch doors			
	regulations in all h Based on observe facility failed to Bistro corridor d frame. This defi any resident staff of the Brookshire Findings include		K0018	K 0018 It is the practice of the facility to have doors protectic corridor openins in other than required closures, vertical openings, exits, or hazardous areas are substantial doors, capable of resisting fire for a least 20 minutes and provide with a means suitable for keet the door closed.1. Corrective Action: No residents were affected.The latching mechan	ng n s t ed eping

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CON	STRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155272	A. BUILE		01	09/07/20	
		100272	B. WING		DDRESS, CITY, STATE, ZIP CODE	00/01/20	
NAME OF F	PROVIDER OR SUPPLIER	L		5226 E 8			
KINDREI		CARE AND REHAB-CASTLETON			POLIS, IN46250		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P.	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG	Maintenance Dir	·		IAG	has been adjusted and door	-	DATE
					latching properly.2. Identifyin	g	
		sistant during a tour of the			others:There is only one set	-	
		35 a.m. to 1:00 p.m. on			Bistro doors. Latching		
09/07/11, the Brookshire Bistro room has one set of double doors each equipped with a positive latching mechanism on the					mechanism (door closure) a of the preventative maintena		
				program and inspected mont			
				for proper functioning. 3.	, l		
door. The positive latching mechanism					Systematic changes:The		
	on each door failed to latch each door into				Maintenance Director/design will educate new employees		
the door frame. Based on interview at the time of observation, the Part Time					fire safety to include proper of		
Maintenance Director stated the positive latching mechanism on each door failed to				closure. Annual fire safety			
				inservices will be conducted	for		
	_	owledged the the			all employees.4. Monitoring: Executive Director and/or		
	•	o door set did not latch			Maintenance Director will rou	ınd	
	each door into th				monthly to ensure that doors		
	each door mito th	le door frame.			locking properly.5. Complian	ce	
	3.1-19(b)				Date: 10-6-02011		
	3.1-19(0)						
K0027	Door openings in s	smoke barriers have at least					
SS=E		rotection rating or are at					
		k solid bonded wood core.					
	•	ve plates that do not exceed bottom of the door are					
		ntal sliding doors comply					
		ors are self-closing or					
		in accordance with					
		ing doors are not required					
		ss and positive latching is 0.3.7.5, 19.3.7.6, 19.3.7.7		-			
		ation and interview, the	K00	)27	K 0027 It is the practice of th	is	10/06/2011
		ensure 1 of 12 sets of			facility to ensure that smoke		
	_	ors would close to form a			barrier doors would close appropriately to form a smoke resistant barrier.1. Correction		
	smoke resistant b	parrier. LSC 19.3.7.6					
	requires doors in	smoke barriers shall			Action- No residents were		
	*				affected. The set of smoke be	arrier	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KNMS21 Facility ID: 000172

If continuation sheet Page 3 of 13

l i		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER: 155272	A. BUII	LDING	01	COMPL 09/07/2	
		155272	B. WIN			09/07/2	011
NAME OF P	ROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP CODE		
KINDRED	TRANSITIONAL (	CARE AND REHAB-CASTLETON		1	82ND ST APOLIS, IN46250		
		STATEMENT OF DEFICIENCIES	_	ID	7.11 0210, 11110200		(V5)
(X4) ID PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	comply with Sec	etion 8.3.4. LSC 8.3.4.1			doors in the corridor near the	;	
	1 5	smoke barriers shall			Physical Therapy room were		
	close the opening leaving only the				realigned such that the doors		
	•	nce necessary for proper			were able to close completel Identifying Others- Smoke ba		
		is defined as 1/8 inch.			doors were inspected and for		
	•	actice could affect any			to be in proper working order	•	
	_	as staff and visitors in			These barrier doors are a pa		
	*	nysical Therapy room if			our preventative maintenanc program and will be inspecte		
	-	ved to move from one			monthly for proper functionin		
	smoke compartn						
					Maintenance Director/design		
	Findings include	•			will educate new employees fire safety to include proper of		
	i mamga maraa				closure. Annual fire safety	1001	
	Based on observ	ation with the Part Time			inservices will be conducted		
	Maintenance Dir				all employees. 4. Monitoring-		
		sistant during a tour of the			Executive Director and	00	
		35 a.m. to 1:00 p.m. on		Maintenance Director/designee will round monthly to ensure			
	•	of smoke barrier doors in			doors are closing properly.5.	The	
		the Physical Therapy			PI committee will audit		
		ne opposite direction and			findings raelated to K 0027 for days.Compliance Date -	or 90	
	<del>-</del>	tely close leaving a one			10-6-2011		
	-	een the set of doors. The					
	• •	m wall side of the smoke					
		was hitting the top part of					
		which caused the door to					
		etely. Based on interview					
	•	servation, the Part Time					
		rector stated the smoke					
		lid not close completely					
		on the atrium wall side					
		op of the door frame and					
	•	ne smoke barrier door set					
		ompletely leaving a one					
		een the set of doors.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
	155272	B. WING		09/07/2011
			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPL	ER		82ND ST	
KINDRED TRANSITIONA	CARE AND REHAB-CASTLETON	I	IAPOLIS, IN46250	
` '	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
, i	ENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
3.1-19(b)  K0029 One hour fire ra	ted construction (with ¾ hour			
fire-rated doors extinguishing sy and/or 19.3.5.4 When the approximate extinguishing sy are separated for resisting partitic self-closing and protective plate from the bottom 19.3.2.1 Based on obset facility failed a serving hazard kitchen and the door frame. The affect any resisting protective plate from the bottom 19.3.2.1  Based on obset facility failed a serving hazard kitchen and the door frame. The affect any resisting protection in the proom.  Findings inclusion.  Findings inclusion.  A Based on of Time Mainten Maintenance of facility from 1 09/07/11, the lame chanical rocclosing devices.	ted construction (with ¾ hour or an approved automatic fire estem in accordance with 8.4.1 protects hazardous areas. It is a protect shazardous areas som other spaces by smoke in shad doors. Doors are non-rated or field-applied is that do not exceed 48 inches of the door are permitted.  The protect of the door are permitted.  The protect of the doors out areas such as the elaundry each latch into the his deficient practice could dent, staff or visitor in the kitchen and the laundry.  The protect of the permitted into the his deficient practice could dent, staff or visitor in the kitchen and the laundry.  The protect of the protect of the permitted into the part and the laundry.  The protect of the protect of the part area of the permitted into the part and the laundry.  The protect of the protect of the part area of the part and the laundry.  The protect of the protect of the part area of the part and the laundry.  The protect of the protect of the part area of the part area of the part and the laundry.  The protect of the protect of the part area of the part a	K0029	K 0029lt is the practice of thi facility to ensure doors servir hazardous areas such as the kitchen and laundry areas cleand latch to prevent the pass of smoke. 1.Corrective Action residents were affected. Both kitchen and laundry room do have been realigned and doc closures adjusted to ensure proper closure.2. Identifying Others:Doors serving hazard areas were inspected and for to be in proper working order These closures are a party of preventative maintenance program and will be inspected monthly for proper functionin Systematic Changes. The Maintenance Director/design will educate new employees fire safety to include proper colosure. Annual fire safety inservices will be	ng e e e e e e e e e e e e e e e e e e e

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  01			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155272	A. BUILDING	ì	01	09/07/2	
		100272	B. WING	EET A	DDRESS, CITY, STATE, ZIP CODE	00/01/2	
NAME OF F	PROVIDER OR SUPPLIER	t			2ND ST		
KINDREI		CARE AND REHAB-CASTLETON			POLIS, IN46250		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREF	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·	TAC	J	conducted for all employees.	1	DATE
		or frame because the door			Monitoring- Executive Director		
		letely close. Based on			and Maintenance		
		time of observation, the			Director/designee will round		
	Part Time Mainte				monthly to ensure that door	_	
	•	ne kitchen door by the			closures are in proper workin order.5. Completion- 10-6-20		
		n would not latch into the			ordono. Completion 10 0 20		
	door frame. b. Based on observation with the Part						
		ce Director and the					
		sistant during a tour of the					
	facility from 10:						
	09/07/11, the laundry room east door set						
		self closing devices and					
	-	mechanisms but the east					
		latch into the door					
		interview at the time of					
		Part Time Maintenance					
		ledged the laundry room					
		latch into the door					
	frame.						
	3.1-19(b)						
K0046	Emergency lightin	g of at least 1½ hour					
SS=F	duration is provide 19.2.9.1.	ed in accordance with 7.9.					
	Based on record	review and interview, the	K0046		K 0046It is the practice of this		10/06/2011
	facility failed to	ensure emergency			facility to ensure that emerge	ncy	
	lighting was prov	vided in accordance with			lighting of at least 1 1/2 hour duration is provided in		
	LSC 7.9 for 3 of	3 battery operated			accordance with 7.9.19.2.9.1	.1.	
	emergency lights	s for 2 of 12 months.			Corrective Action- No residents were affected. The battery		
		dic Testing of Emergency					
	Lighting Equipm	nent requires a functional			operated emergency light loc	ateu	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KNMS21 Facility ID: 000172

If continuation sheet Page 6 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND FLAN	OF CORRECTION	155272	A. BUII		01	09/07/2	
		100272	B. WIN		DDDECC CITY CTATE ZIR CODE	00/01/2	
NAME OF P	ROVIDER OR SUPPLIEF	2		1	ADDRESS, CITY, STATE, ZIP CODE 82ND ST		
KINDRE	O TRANSITIONAL (	CARE AND REHAB-CASTLETON		1	APOLIS, IN46250		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
		eted at 30 day intervals			at the generator worked propupon inspection, however no		
	and an annual test to be conducted on				documentation to show the		
		attery powered emergency			monthly test was provided. T	he	
		for not less than 1 ½ hour			monthly testing is now includ		
		ment shall be fully			on the Generator Preventativ		
	operational for the duration of the test.				Maintenance Log Sheet. The facility has undergone a char		
		of visual inspections and			in the Maintenance Director	J-	
	•	ot by the owner for			position and the new Directo		
	inspection by the authority having jurisdiction. This deficient practice could				be in place by October 1, 20		
					Identifying Others- There is one battery operated back up		
	affect all occupants in the facility including staff, visitors and residents if				light for the generator and it		
					in proper working order at the		
	the facility were	required to evacuate in an			time of the inspection.3.		
	emergency durin	g a loss of normal power.		Systematic Changes- Monthly testing of the battery operated			
	Findings include	:		back up light for the generator is now included in the monthly Generator Preventative	or is		
	Based on review	of "Fire/Disaster Drill			Maintenance Log Sheet.		
	Report" docume	ntation with the Part Time			Executive Director/ Maintena mentor will educate new	ince	
	-	rector from 8:55 a.m. to			Maintenance Director on the		
	10:35 a.m. on 09	0/07/11, documentation of			completion of the log.4.		
		g at 30 day intervals for			Monitoring- Executive Director	or	
		ttery powered emergency			and Maintenance		
		vailable for review for			Director/designee will review Generator Preventative		
	_	11. Based on interview			Maintenance Log monthly x	3	
	_	cord review, the Part Time			months and then quarterly		
		rector stated the facility			thereafter to ensure	ato	
		powered emergency			compliance.5. Compliance D October 6, 2011.	alt-	
	<u>-</u>	e generator location and					
	- '	er switch room) and					
		nere was no written record					
		ection test regarding the					
	_	emergency lights for June					
		ilable for review.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MU	ILTIPLE CON	NSTRUCTION 01	(X3) DATE S COMPL		
ANDILAN	or correction	155272	A. BUIL		01	09/07/2	
NAME OF B	DOWNER OF CLIRRY IED		B. WINC		DDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER				32ND ST		
		CARE AND REHAB-CASTLETON		INDIANA	APOLIS, IN46250		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	,	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
K0050 SS=F	Fire drills are held varying conditions shift. The staff is f is aware that drills routine. Responsi conducting drills is competent person exercise leadershi conducted betwee announcement ma audible alarms.  Based on record the facility failed conducted on the quarters. This deall occupants in tresidents, staff ar Findings include  Based on review Report" documer Maintenance Dir 10:35 a.m. on 09 documentation ar fire drill conduct the fourth quarter interview at the tent Time Maintenance Dart Time Dart Time Maintenance Dar	at unexpected times under, at least quarterly on each familiar with procedures and are part of established bility for planning and assigned only to s who are qualified to p. Where drills are n 9 PM and 6 AM a coded by be used instead of 19.7.1.2 review and interview, a to document fire drills be third shift for 1 of 4 deficient practice affects the facility including and visitors.  The control of the control	K0	050	K 0050lt is the practice of this facility to conduct quarterly fill drills on all three shifts and known proper documentation of the drills. 1. Corrective Action- Notes and the proper documentation of the drills. 1. Corrective Action- Notes are affected.  Executive Director is monitor quarterly fire drill documentate to ensure that they are being completed, documented corrector will be in place by October 1, 2011.2. Identifying Others- Quarterly fire drills at being conducted by the Maintenance Director/design Systematic Changes- Execut Director will monitor the quarfire drill documentation to ensure that it is being documented correctly and readily accessil	re eep o ing tion ectly ee.3. tive terly sure	10/06/2011
	fire drill conduct the fourth quarter interview at the t	ed on the third shift for r of 2010. Based on ime of record review, the enance Director			Systematic Changes- Execut Director will monitor the quar fire drill documentation to ens that it is being documented	tive terly sure ble	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155272	B. WING			09/07/2	011
NAME OF B	DOLUDED OD GLIDDI IED		F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			5226 E	82ND ST		
	TRANSITIONAL C	CARE AND REHAB-CASTLETON		INDIAN	APOLIS, IN46250		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	quarterly fire drill documenta	tion	DATE
		vailable for review of a			to ensure that it is being	lion	
		onducted on the third shift			documented correctly and re	adily	
	for the fourth qua	arter of 2010.			accessible upon request. 5.		
					PI committee 5. Completion	Date-	
	3.1-19(b)				October 6, 2011.		
K0069	Cooking facilities a	are protected in accordance					
SS=E	with 9.2.3. 19.3.						
	Based on record	review and interview, the	K0	069	K 0069It is the practice of thi	s	10/06/2011
	facility failed to ensure 1 of 1 kitchen				facility to ensure that cooking	J	
	-	was cleaned at least			facilities are protected in		
	•	FPA 96, 1998 Edition,			accordance with 9.2.3.19.3.2 NFPA 96.1. Corrective Action		
	•	tilation Control and Fire			Taken - No residents were	•	
		mmercial Cooking			affected. The kitchen exhaust system was cleaned on		
		requires hoods, grease					
	•	fans, ducts, and other			6-25-2010, 4-16-11. Kitchen		
		all be cleaned to bare			exhaust system was also cle on 9-9-11 by Good Exhaust	aneu	
		intervals prior to			Cleaning , LLC.2. Identifying		
	•	ng heavily contaminated			Others- Does not involve any	<i>'</i>	
		ly sludge. After the			other system.3. Systematic	4-	
	_	s cleaned to bare metal, it			Change - Executive Director contract with Good Exhaust	ιο	
					Cleaning, LLC for scheduled		
		ed with powder or other			cleaning of kitchen exhaust		
		entire exhaust system			system. Also, part of Prevent	ative	
	_	d by a properly trained,			Maintenance program that		
		rtified company or			Maintenance Director is responsible to oversee.4.		
		ordance with Table 8-3.1.			Monitoring- Executive Director	or	
	•	res systems serving			and		
		e cooking operations shall			Maintenance Director/design		
	•	iannually. This deficient			monitor for compliance and t ensure documentation is eas		
	-	fect any resident, staff or			accessible. 5. The PI commit		
	visitor in the vici	nity of the kitchen.			Compliance Date- October 6		
					2011.		
			l				

000172

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155272	B. WING		09/07/2011
NAME OF F	PROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE	
KINIDDEI	TDANGITIONAL (	CARE AND REHAB-CASTLETON		82ND ST IAPOLIS, IN46250	
				HAPOLIS, IN40250	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
	Findings include	·			3.112
	i mamgs merade	•			
	Rased on review	of Good Exhaust			
		Invoice" records with the			
	-	enance Director from			
		35 a.m. on 09/07/11,			
		ndicated the kitchen			
		vas last cleaned on			
	•	s previously cleaned on			
		documentation of			
		ning after 06/25/10 was			
		iew. Based on interview			
		cord review, the Part Time			
	Maintenance Dir				
		ning was performed after			
	06/25/10 and ack	-			
		f semiannual kitchen			
		cleaning after 06/25/10			
	was available for	_			
	was available for	Teview.			
	3.1-19(b)				
	3.1 15(0)				
V0144	Generators are in	spected weekly and			
K0144 SS=F		pad for 30 minutes per			
00-1	month in accordar	•			
	3.4.4.1.			120444111211111111111111111111111111111	
		ord review and interview,	K0144	K 0144It is the practice of thi facility to inspect generators	is 10/06/2011
	_	I to ensure a complete		weekly and to exercise unde	ır İ
		weekly inspections of		load for 30 minutes per mon	
	_	ries for the emergency		accordance with NFPA	
	generator was ma	aintained for 3 of 52		99.3.4.4.1.1. Corrective Action	on -

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155272 09/07/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5226 E 82ND ST KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON INDIANAPOLIS, IN46250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE weeks. Chapter 3-4.4.1.3 of NFPA 99 No residents were affected. Maintenance Director position requires storage batteries used in has been changed and the new connection with essential electrical Director to be in place by Oct.1, systems shall be inspected at intervals of 2011. New Director has been educated by the Executive not more than 7 days and shall be Director on the proper testing of maintained in full compliance with the generator and documentation manufacturer's specifications. Defective requirements. Facility has batteries shall be repaired or replaced contracted with Buckeye Power to immediately upon discovery of defects. have a remote manual stop installed on the generator.2. Furthermore, NFPA 110, 6-3.6 requires Identifying Others- Records were checking storage batteries, including maintained for the other 49 electrolyte levels, at intervals of not more weeks of the year of the starting than 7 days. Chapter 3-5.4.2 of NFPA 99 batteries for the emergency generator.3. Systematic requires a written record of inspection, Changes- Executive Director performance, exercising period, and contracting with Buckeye Power repairs for the generator to be regularly for Preventative Generator maintained and available by the authority Maintenance to include full load testing, as well as updating having jurisdiction. This deficient generator to regulatory code practice could affect all residents, staff changes. 4. Monitoring- Executive and visitors. **Director and Maintenance** Director/designee to validate the remote manual stop has been Findings include: installed on the generator and contract has been implemented. Based on review of "Emergency 5. The PI Committee will audit Generator Monthly Log Sheet/Weekly compliance related to K0144 for 6 months. Compliance Date-Engine Exercise" documentation with the October 6, 2011. Part Time Maintenance Director during record review from 8:55 a.m. to 10:35 a.m. on 09/07/11, weekly emergency generator starting battery inspection records for the fifty two week period from 09/03/10 through 08/26/11 was documented and maintained except for the first three weeks of April 2011. The only

<b> </b> 155272			LDING	ONSTRUCTION  01	(X3) DATE: COMPL 09/07/2	ETED	
NAME OF I	DD OVADED OD CLIDDI IEI	<u> </u>	P. 112		ADDRESS, CITY, STATE, ZIP CODE	1	
	PROVIDER OR SUPPLIEI			1	82ND ST		
KINDRE	D TRANSITIONAL	CARE AND REHAB-CASTLETON	N	INDIAN	APOLIS, IN46250		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG	+	of weekly starting battery		IAG	Burelinery		DATE
		pril 2011 available for					
	review was for the week of 04/29/11.						
		ew at the time of record					
		Time Maintenance					
	Director acknow						
	1	of weekly battery					
	inspections for t	he first three week period					
	of April 2011 wa	as available for review.					
	3.1-19(b)						
		ervation and interview,					
	1	d to ensure 1 of 1					
		rators was equipped with					
		stop. NFPA 99, Health					
		3-4.1.1.4 requires					
	1 ~	stalled as alternate power					
	1	et the requirements of dard for Emergency					
	1	0 ,					
	1 -	Systems. NFPA 110, Level II installations shall					
	1	anual stop station of a					
		break glass station					
	1 * *	of the room where the					
		ocated. NFPA 110, 7-1					
	1 ^	Standard for the					
		Use of Stationary					
		gines and Gas Turbines,					
	1	ory requirements for					
	emergency gene	rators and shall be					
	considered part	of the requirements of this					
	standard. NFPA	37, 8-2.2(c) requires					
	emergency gene	rators of 100 horsepower					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KNMS21 Facility ID: 000172

If continuation sheet Page 12 of 13

<b> </b> 155272		(X2) MU A. BUILI B. WING	DING	NSTRUCTION  01	(X3) DATE S COMPL 09/07/20	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u>.</u>			DDRESS, CITY, STATE, ZIP CODE		
KINDREI	O TRANSITIONAL (	CARE AND REHAB-CASTLETON			32ND ST APOLIS, IN46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
TAG	of more have prodown the engine remote location. could affect all rivisitors.  Findings include Based on observing Maintenance Dim Maintenance Assignation from 10: 09/07/11, no evidevice was found fired emergency information on the did not indicate assed on interving observation, the stated the emerginstalled at least acknowledged the	at the engine and from a This deficient practice esidents, staff and  ation with the Part Time rector and the sistant during a tour of the 35 a.m. to 1:00 p.m. on dence of a remote shut off d for the 100 kW diesel generator. Nameplate he emergency generator the year of manufacture. ew at the time of Maintenance Assistant ency generator was eight years ago and here is no remote off device for the		TAG	DEFICIENCY)		DATE